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Submission to the Senate Community Affairs References Committee on

Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation".

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Thank you for the opportunity to contribute to this crucially important topic.

The Doctors Reform Society is an organisation of doctors and medical students which formed in 1973 to support the introduction of a universal health insurance scheme (Medibank). It is an organisation which continues to advocate for a health system which aims to address all preventable causes of poor health outcomes.

Addressing Social Determinants of Health in Australia

Structural Change or Targeted Charity

In their final report in 2008, the Commission on Social Determinants of Health (CSDH) called *'on the World Health Organisation and all governments to lead global action on the social determinants of health with the aim of achieving health equity.'* (CSDH 2008)

The report of the Commission had three main recommendations.
1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess impact of action

It also emphasised that health and illness follow a social gradient and that it is not just about addressing the most disadvantaged.

This submission outlines some of the most obvious inequities in health outcome and status in Australia and then discusses the situation with respect to the first two recommendations and finally makes several recommendations to improve the domestic response to the "Closing the gap within a generation" report.

Inequities

‘ the absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically.’(Starfield 2002)

The most obvious example of the lack of health equity is the 11 year life expectancy difference between indigenous Australians and the rest of the population. (Australian Bureau of Statistics, [ABS] 2010). But there are also cross sectional data showing the effect of socio-economic status and of geography on health outcomes. Using the Index of Relative Socio-economic Disadvantage (IRSD) and data from the Australian Institute of Health and Welfare (AIHW), Draper showed a consistent gradient of increasing mortality across the five quintiles of IRDS for children and for adults (Draper 2004). Thus males in the most disadvantaged quintile had an age adjusted mortality rate 80% higher than those in the least disadvantaged quintile. Similarly, the mortality rate for females was 50% higher.

Using the Accessibility/Remoteness Index of Australia (ARIA), Draper also showed a gradient of increasing mortality across four different categories of accessibility/remoteness from most accessible to least accessible/most remote in both males and females, particularly in the 25-64 year age group. Thus, both males and females in the most remote category had mortality rates 80% higher than those in the most accessible category. Most but not all of these differences were attributable to the increased mortality of indigenous Australians (Draper 2004).
In addition to this cross sectional data, Draper also demonstrated that although all cause mortality has been falling with time across socio-economic quintiles, the rate ratios or relative mortality inequalities have been increasing for most age groups, particularly for males (Draper 2004)

Improving the daily living conditions

Improving the daily living conditions involves an emphasis on early childhood development, fair employment and decent work, having a universal social welfare system, and universal health care. In Australia a comprehensive framework for early childhood education and care is being implemented. Recent policies are intended to improve employment, especially amongst the disadvantaged. Our social welfare system is well targeted but there is evidence it is far from generous compared to other rich countries, despite the fact that child poverty levels in Australia are higher than the mean for 20 rich countries (Unicef 2010).

The Commission regards the provision of universal health care as an essential part of improving daily living conditions and health care as ‘a common good rather than a market commodity’. We have a universal health system which guarantees entitlement but not access. There are significant financial, geographical, physical, and cultural barriers to access across Australia. A survey of 26,000 Australians by the Australian Bureau of Statistics (ABS) found that 8.2 % delayed or did not see a general practitioner (GP) in a year because of cost, 11.9% delayed or did not see a specialist because of cost, and 9.2% delayed or did not obtain a prescribed drug because of cost (ABS 20011). Rather than looking at the general population, the Commonwealth Fund survey from 2005 was performed on sick Australians, those who had recently been hospitalized, had surgery, or reported health problems. In this group who are the very ones whose access should be facilitated by a health system, 30% described access problems due to cost. Thus, 16% didn’t fill a prescription, 17% did not see the doctor when sick, and 19% did not get recommended test or follow-up (Schoen 2005).

Geographical barriers to access continue despite many targeted programs to improve distribution of the workforce. Using the Australian Standard Geographical Classification (ASGC), the Productivity Commission found that population to practitioner ratios in very remote areas for GPs, dentists, and physiotherapists are about 20% that found in major cities but importantly there is a steady gradient of decreasing availability as one moves from major cities, through inner regional, outer regional to remote and very remote (Productivity Commission 2005).

Whilst there are many factors contributing to the unequal distribution of the medical workforce, most of these factors are largely or completely out of control of government. The method of funding however is determined by government. It has chosen to persist with fee for service plus copayment as its main funding mechanism. This inevitably contributes to the medical workforce distributing itself in areas where copayments can be afforded, and where lifestyle choices of the workforce are optimised. Although many programs have been devised to counteract this poor distribution of workforce, the success of such programs will always be limited as they are working in direct conflict with the major funding structure.

The main funding of health care outside public hospitals in Australia is through fee for service plus copayment. This applies to most GP services and specialist services, private hospital services, and increasingly now to psychologists, nurse practitioners, physiotherapists and other allied health professionals. Thus health professionals paid in this way are free to provide publicly subsidised services wherever the market will support them and at whatever level of copayment the market will support. Financial and geographical barriers to access are inevitable. This structure reflects a view of health care as a market commodity rather than a common good. Rather than addressing this structure, the government is expanding it to more groups and entrenching inequity. This basic funding structure is ripe for change.

Tackle the inequitable distribution of power, money, and resources

The distribution of power, money, and resources is seen by the Commission as a key structural driver of conditions of daily life.

We know from Wilkinson that income inequality rather than income per se correlates with health and well being status in developed countries (Wilkinson 2010). We also know that on most comparative measures of disposable income over the period 1994 to 2008, there has been increasing inequality in Australia (ABS 2011). But the approach of the Government to the inequitable distribution of power, money and resources is limited although well directed in parts. Thus, improving employment, long term plans for improved housing affordability and availability, etc will all help to address these inequity issues. Some changes resulting from the recent budget are very directly aimed at redistributing income but are minor and predominantly relate to compensation for the carbon tax. Other changes such as the move of single mothers from pension to Newstart will increase inequity .for those mothers who can't or don't find enough employment. The lack of any improvement in the Newstart allowance continues to contribute to income inequality with all its consequences.

The inequitable distribution of power, money, and resources is not just about income and the tax system however. The increasing emphasis on individualism must be considered if we are to address inequities. Individualism is required to encourage innovation and excellence but the potential price is the decline of community, of a sense of belonging, of links to others which are critical to healthy lives. In the absence of those connections in a competitive environment, materialism thrives and

lives become increasingly empty. We see the effects in our consulting rooms, patients desperate for an explanation for their complaints which are so often the result of 'burning the candle at both ends', keeping up with the pack, or simply being left behind. Whether these issues are the result of the promotion of the individualist ideology of neoliberalism and the materialism with which it is often associated, or the result of the perception of loss of control over life events due to relative income inequality is debatable ie is this a chicken and egg scenario, but to ignore this part of the problem of inequity and ill health is to hide one's head in the sand. This aspect of the issue is not one which is addressed in the CSDH report.

The Commission states that to tackle this issue requires

' a strong public sector that is committed, capable, and adequately financed' (CSDH 2008).

Such a requirement is not evident in our health system. Over the last several years Ministers for Health have noted with apparent pleasure an increase in the uptake of private health insurance. Whilst this attitude is understandable in terms of the political process of means testing the private health insurance rebate, it needs to be appreciated that this growth occurs because of the perception by the public that the public system, particularly the hospital system is increasingly inadequate.

What about a strong public sector for primary health care? Primary health care is largely publicly funded but predominantly runs on a small private business model. Between 2003-4 and 2007-8 there was over 20% increase in Emergency Department presentations, with no change in the make-up of the triage categories. 13% were non urgent and 46% semi-urgent (Australian Institute of Health and Welfare 2010). The increase in Emergency Department presentations for problems which could be addressed in general practice would suggest that our publicly subsidised private primary health care system is failing as patients default to the Emergency Departments. The way general practice is both structured and functions is changing. There has been a 51% decrease in home visits from 1997 to 2007 (Joyce and Piterman 2008), and a 37% decline in the proportion of GPs working in practices that provide their own after-hours services (Britt 2010), contributing to the use of Emergency Departments. In addition, there is an increasing need for a more robust business model as the number of solo practices decrease and the number of large practices of more than 10 GPs increases (Britt 2010). Corporate entities have become increasingly involved in these larger practices and some are publicly listed companies whose bottom line is profit (Friedman 1970). Primary Health Care Ltd is one such company which rose to prominence in the early 2000s as a profitable bulk billing GP chain at a time when bulk billing rates were falling across the country. In 2009 this company abandoned bulk billing in many of its clinics (Invest Smart 2011). By that time it had diversified into radiology and pathology. The decision to abandon bulk billing and impose a barrier to access was financial, but clearly not directly related to the level of the rebate as the rest of the country's GPs had taken the bulk billing rate up almost to the historic high of 80% (Medicare Australia 2010). Such corporate entities are not part of a strong public sector but are publicly funded private entities. This trend to increasing corporate involvement which is mirrored in radiology, pathology, and private hospitals, is not indicative of a Government presiding over a strong public sector.

More broadly there exist inequalities in access to education, housing, and employment opportunities (Argy 2006). Education funding structures are controlled largely by government. Despite the plan to implement many features of the Gonski review of education, this plan if implemented will still see a two tiered primary and secondary education system, unlike eg Finland where private schools don't exist and educational achievement is amongst the highest in the world. These and other factors will continue to contribute to inequities in health outcomes.

Current approaches to inequities

There are a variety of ways in which these different inequities are addressed in Australia. Charitable organisations frequently help the most disadvantaged, for housing, employment, education or access to health care. Another form of charity is exemplified by the doctor or other health professional who chooses not to charge a copayment (bulk bill) or another type of professional who goes way beyond the expectations of their position to help the disadvantaged. The third form of charity comes from government. It is the system of safety nets introduced to address the gross inequities in access to health, quality education, housing, food security, and all of the other social determinants. Such safety nets are required because the societal structures result in inequities. Many of these structures are largely or entirely due to government policy eg, a copayment is required for pharmaceutical but 22% sick Australians don't fill a prescription because of cost (that's even with a safety net).

Governments frequently correctly identify disadvantaged groups and introduce programs or projects specifically targeted to such groups. Such an approach is entirely appropriate when combined with addressing the structural drivers of such inequity. This approach aims for equity. When targeted programs are not combined with addressing the structural problems however, the approach is aiming only to reduce gross inequity. In such situations, one could consider programs as yet another form of charity, picking up the pieces resulting from structures of the government's own making.

The approach to the vexed question of the health of indigenous Australians has demonstrated an understanding of the broad range of factors contributing to health inequity. Recent funding for mental health with targeted funding initiatives across different areas including housing, education, and employment, is recognition of the range of social determinants, and the mechanisms of funding do begin to address the structural problems of funding through fee for service (National Mental Health Reform 2011). The inclusion in the functions for Medicare Locals of a population health approach is also encouraging (Department of Health and Aging 2010), but to date there is no evidence of the recognition of the structural barriers to equitable funding and access with which Medicare Locals will have to contend to fulfil its multiple functions. Whilst these initiatives are encouraging the general approach to health care and health reform has been to ignore the structural drivers of inequity whilst addressing some areas of gross inequity.

These targeted approaches to gross inequity reflect a lack of consideration of the structural causes but also reflect a lack of regard for the social gradient of inequity. This gradient means that for example those in the 2nd highest quintile for health outcomes are still disadvantaged compared to those in the highest quintile.

This is further exemplified by the well intentioned appointment by the Federal Government of the Australian Social Inclusion Board (ASIB) which states its task as:
It is the main advisory body to the government on ways to achieve better outcomes for the most disadvantaged in our community and to improve the social inclusion in society as a whole (ASIB 2008)It is puzzling that the task of the Board is not to aim for better outcomes (health or other) for all.

Barriers to addressing social determinants

There does not seem to be sufficient recognition that there are fundamental structural barriers to equity in our society, particularly in the health and education systems and in income distribution. There also appears to be a lack of recognition of the social gradient, which therefore supports the concept of targeting the most disadvantaged and ignoring those structural barriers.

Instead, the approach to health inequities appears to be largely focused on targeted programs, safety nets, and other forms of charity. The other concern about a reliance on charity is that it deflects those interested in equity from pursuing that idea through the much harder to achieve structural reform. Those who spend all their time in charity work including well targeted programs, feel they are doing the right thing. They are. But whilst they may believe strongly in equity, they have no time left for the pursuit of the big changes required. Politicians who start off with ideals of equity must turn into practical people, doing what is possible. Thus, even the well intentioned target gross inequity and feel they are doing well, and then they ignore or have no time and energy to address the structures which are amenable to change. The changes required to tackle the root causes of the inequity are major, but what is being done is minor if not minimal. For other politicians, targeting gross inequity is perfect as they don't actually believe in equity, and much prefer the idea of charity, which fits well with their belief in a class based tiered society.

Recommendations

Recognition of the importance of social determinants is a first step and should not be hard as that recognition already has multiparty support in relation to the health and well being of Aboriginal and Torres Strait Islanders. It should apply to all Australians. An appreciation that health status and outcomes follow a social gradient is also required and that is currently poorly appreciated.

At the political level we recommend a **Health Equity in All Policies** approach as has been taken by the South Australian Government. Crucial to the success of such an initiative is support at the highest level of government. Without the leadership from the Prime Minister, the approach will be as weak as many environmental impact assessments.

The arguments for addressing social determinants might be divided into the moral and the economic. Health equity for us is a matter of social justice. Everyone should be given the opportunity to fulfil their potential. Preventable causes of inequity should be addressed by government as the private sector will not be inclined or capable. For those who are not persuaded by the moral argument however, there is an economic argument. The shear waste of productivity in our society due to imprisonment of the unhealthy who commit crimes to feed addiction or under the influence of addiction, frequently combined with another treatable but untreated or undertreated mental illness, the unnecessary investigation and management of preventable diseases, the decreased employment opportunities for people because of untreated preventable conditions, is fertile ground for an economic argument to address social determinants. We recommend that a **Productivity Commission** address the economic cost of not addressing social determinants with the expectation that this will add further strength to the moral argument.

Conclusion

There is recognition amongst many of our politicians that to achieve health equity one needs to address both the health system and many factors outside the health system. There is a failure of recognition however that heath inequity follows a social gradient, and structural change is required to address this issue. A targeted approach to the most affected groups ignores this gradient and ignores the structural causes of the inequities. Indeed, one could view the approach of relying just on targeting as another form of charity, striving to reduce gross inequity but ignoring the goal of equity.

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